STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155095	A. BUILDING 00 B. WING	10/21/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE PARK	2001 HOBSON RD FORT WAYNE, IN46805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Investigation of Complaint #IN00098450. Complaint #IN00098450-Substantiated. Federal/state deficiencies related to the allegation are cited at F325 and F464. Survey dates: October 20, 21, 2011 Facility number: 000038 Provider number: 155095 AIM number: 100274830 Survey team: Ann Armey, RN TC Diane Nilson, RN Census bed type: SNF: 18 SNF/NF: 145 Total: 163 Census payor type: Medicare: 14 Medicaid: 108 Other: 41 Total: 163 Sample: 5 This deficiency reflects state findings cited in accordance with 410 IAC 16.2.	F0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.This provider respectfully requests that the 2567L Plan of Correction be considered the Letter of Credible Allegation.Based on past survey history and no harm identified to any resident; this facility respectfully requests a desk review in lieu of a post-survey revisit on or after November 7, 2011.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155095	A. BUILDING 00 B. WING	10/21/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE PARK	2001 HOBSON RD FORT WAYNE, IN46805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Quality review completed on October 24, 2011 by Bev Faulkner, RN			
F0325 SS=D	Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on observation, interview, and record review, the facility failed assess the resident's nutritional status and implement new interventions to address a significant weight loss. This deficiency affected 1 of 3 residents whose weight loss was reviewed in a sample of 5. (Resident #B) Findings include: On 10/20/11 at 10:00 a.m., during the entrance tour, accompanied by the ADON (Assistant Director of Nursing), Resident #B was observed in bed covered by a blanket. On 10/20/11, between 12:10 p.m. and 12:45 p.m., Resident #B was observed in	F0325	F325-MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLEIt is the practice of this provider to ensure that the resident (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. However, based on the alleged deficient practice the following has been implemented:What corrective action will be accomplished for those residents found to have been affected by the deficient practice:Resident B:Resident continues to be weighed and reviewed at the Nutrition At Risk Interdisciplinary Team Meeting	11/07/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155095	A. BUILDING 00 B. WING	10/21/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE PARK	2001 HOBSON RD FORT WAYNE, IN46805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the main dining room. The resident was in a low wheelchair and sitting at a table. Her chin was at the table level. She was drinking coffee and had to reach up to retrieve the coffee mug. When she finished the coffee, she left the table and propelled herself in the wheelchair back to her room. She was returned to the restorative table in the dining room. The resident's chin was again level with the table top and she had to reach up to retrieve the drinking glasses and food. There was a staff person present, who provided verbal prompts. The resident ate one hundred percent of her ice cream from a bowl she held in her hand and drank the fluids, but did not eat the food on the plate. The clinical record of Resident #B was reviewed on 10/20/11 at 1:30 p.m., and indicated the resident was admitted to the facility on 3/1/10, with diagnoses which included but were not limited to, dementia, weakness, and hypothyroidism. The quarterly assessment, dated 9/6/11, indicated the resident had severe cognitive impairment and required limited assistance with eating. The weight record, provided by the ADON (Assistant Director of Nursing), indicated Resident #B's weights were as		weekly.Supervision is provided to ensure resident is encouraged to consume meal.The Dietary Manager has reviewed food preferences with the resident.The resident was assessed by an Occupational Therapist and is seated at a table appropriate to meet her needs.Resident receives an oral supplement BID.Resident is provided snacks between meals.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:No other residents were found to have been affected by the alleged deficient practice.Residents presenting with a significant weight loss have the potential to be affected by the alleged deficient practice.Residents with weight or nutritional concerns are reviewed weekly by the Interdisciplinary Team at the Nutrition At Risk Meeting.Team members attending the Nutrition At Risk Meeting have been re-educated. Education includes but is not limited to residents to be reviewed, intervention expectations and determining effectiveness.Education provided November 4, 2011 by the Director of Nursing Services.The Director of Nursing Services/Certified Dietary Manager is responsible for oversight to ensure compliance.What measures will be put into place or what systemic	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155095	A. BUILDING 00 B. WING	10/21/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE PARK	2001 HOBSON RD FORT WAYNE, IN46805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	follows: On 4/1/11, 99 pounds; On 5/1/11, 100 pounds; On 6/1/11, 96 pounds: On 7/1/11, 96 pounds; On 8/1/11, 95 pounds; On 9/1/11, 89 pounds; On 9/6/11, 88 pounds; and On 10/18/11 (the most current weight), was 84 pounds. The weight record indicated Resident #B lost 15 pounds or 15 percent of total body weight in six months (between 4/1/11 and 10/18/11) and lost 6 pounds or 6.3 per cent of total body weight in one month (between 8/1/11 and 9/1/11). The care plan to prevent further significant weight loss, dated 1/25/11, included the following interventions: Honor known food preferences, Monitor food and fluid intake at meals Monitor weight, Notify MD/family of significant weight loss, Offer substitute if less than 75% of any meal is consumed, Provide diet as ordered, and Review labs if available. All of the above interventions were dated 1/25/11. On 4/18/11, the resident's regular diet was		changes you will make to ensure that the deficient practice does not recur:The Dietary Manager reviews weekly and monthly weights.Based on the Dietary Managers recommendation-residents with weight or nutritional concerns are reviewed weekly by the Interdisciplinary Team at the Nutrition At Risk Meeting.A Dining Room Manager observes dining service to ensure preferences, appropriate positioning and assistance is provided. Team members attending the Nutrition At Risk Meeting have been re-educated. Education includes but is not limited to residents to be reviewed, intervention expectations and determining effectiveness.Education provided November 4, 2011 by the Director of Nursing Services.The Director of Nursing Services/Certified Dietary Manager is responsible for oversight to ensure compliance.How the corrective action(s) will be monitored to ensure the deficient practice will not recur: A CQI monitoring tool titled "Weight Loss" will be utilized every week x 4, monthly x 3 and quarterly thereafter by the Dining Room Monitor.Data will be submitted to the CQI committee. If the threshold of 90% is not met, an action plan will be developed.Non-compliance with facility procedure may result in disciplinary action up to and including termination.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155095	A. BUILDING 00 B. WING	10/21/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE PARK	2001 HOBSON RD FORT WAYNE, IN46805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	discontinued and a regular diet with fortified foods was ordered. There was no documentation new interventions were implemented, to address the resident's weight loss between 5/1/11 through 9/1/11 and no documentation the effectiveness of the fortified foods was assessed. On 1/25/11, dietary notes indicated the resident was assessed by the Registered Dietician but there were no further notes or recommendations, from the Registered Dietician, regarding the resident's significant weight loss, until 10/20/11 (nine months later). On 9/6/11, dietary notes, written by the Dietary Manager, indicated "Resident remains on a regular diet with fortified foods. Ht. (height) 61 inches Wt (weight) 95 pounds, BMI (Body Mass Index)18 which is below the recommended guidelines...consumptions...overall 35% of meals offered. No chewing or swallowing problems on current diet. Will continue to follow." The weight of 95 pounds in the dietary note, did not correspond to the 88 pound weight recorded on Resident #B's weight record for 9/6/11. Interdisciplinary notes were reviewed.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155095	A. BUILDING 00 B. WING	10/21/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE PARK	2001 HOBSON RD FORT WAYNE, IN46805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The note, dated 9/13/11, indicated the resident had significant weight loss, the resident's average consumption was 34% and recommended an Occupational Therapy screening. The Occupational Therapy Screening, dated 9/14/11, indicated the resident was able to feed herself without difficulty and no recommendations were made. The interdisciplinary note, dated 9/28/11, indicated the resident's average consumption was 24% and indicated the resident was screened by the Speech Therapist. Speech therapy notes, dated 9/28/11, indicated the resident might benefit from a 4th meal group provided by therapy, but the resident's power of attorney declined the therapy services. There were no further recommendations. Physician progress notes, dated 9/30/11, indicated "no new concerns per staff." On 10/4/11, (a month after the significant weight loss was identified) the resident's care plan was updated and the resident was placed in an eating/swallowing program to "Give verbal cues and reminders to take bite (sic), and verbal prompts to stay on task." the program was 7 days a week, 2 meals a day.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155095	A. BUILDING 00 B. WING	10/21/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE PARK	2001 HOBSON RD FORT WAYNE, IN46805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Subsequent weight records indicated the resident lost an additional four pounds between 10/4/11 and 10/18/11. On 10/21/11 at 10:00 a.m., the Registered Dietician was interviewed and indicated she had not done an assessment or made recommendations for Resident #B because she was not aware of the resident's significant weight loss until 10/20/11. She indicated the dietary note, dated 9/6/11, was written the day after a holiday and the weight used by the Dietary Manager, for the assessment, was probably from the previous month and as a result did not address the resident's weight loss. The Dietician indicated Resident #B's BMI (Body Mass Index), on 10/21/11, had declined and was now 17.2. The Registered Dietician indicated the normal BMI range was 19-25. On 10/21/11 at 10:30 a.m., the Activity Director was interviewed. She indicated the resident enjoyed the cookies and drinks provided during the twice weekly mocktail activity. The policy for weight and nutritional concerns, dated 1/10, provided by the Director of Nursing, was reviewed on 10/21/11 at 11:00 a.m. and indicated			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155095	A. BUILDING 00 B. WING	10/21/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE PARK	2001 HOBSON RD FORT WAYNE, IN46805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	"...(if not gaining weight)... *Review of RD (Registered Dietician) recommendations and follow up *Update to care plans..." This Federal tag relates to Complaint IN00098450 3.1-46(a)(1)			
F0464 SS=D	The facility must provide one or more rooms designated for resident dining and activities. These rooms must be well lighted; be well ventilated, with nonsmoking areas identified; be adequately furnished; and have sufficient space to accommodate all activities. Based on observation, interview, and record review, the facility failed to assure the height of a dining table was appropriate for a resident sitting in a wheelchair who had experienced weight loss. This deficiency affected 1 of 3 resident's whose weight loss was reviewed and who were observed in the dining room, in a sample of 5. (Resident #B) Findings include: On 10/20/11, between 12:10 p.m. and 12:45 p.m., Resident #B was observed in the main dining room. The resident was in	F0464	F464: REQUIREMENTS FOR DINING & ACTIVITY ROOMSIt is the practice of this provider to ensure resident dining and activity rooms are well lighted; are well ventilated, with nonsmoking areas identified; be adequately furnished; and have sufficient space to accommodate all activities.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:Resident B:Resident is seated at a table of appropriate height for dining.How will you identify other residents having the potential to be affected by the same deficient practice and what	11/07/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155095	A. BUILDING 00 B. WING	10/21/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE PARK	2001 HOBSON RD FORT WAYNE, IN46805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	a low wheelchair and sitting at a table. Her chin was at the table level. She was drinking coffee and had to reach up to retrieve the coffee mug. When she finished the coffee, she left the table and propelled herself in the wheelchair back to her room. She was returned to the restorative table in the dining room. The resident's chin was again level with the table top and she had to reach up to retrieve the drinking glasses and food. There was a staff person present, who provided verbal prompts. The resident ate one hundred percent of her ice cream from a bowl she held in her hand and drank the fluids but did not eat the food on the plate. The clinical record of Resident #B was reviewed on 10/20/11 at 1:30 p.m., and indicated the resident was admitted to the facility on 3/1/10, with diagnoses which included but were not limited to, dementia, weakness, and hypothyroidism. The quarterly assessment, dated 9/6/11, indicated the resident had severe cognitive impairment and required limited assistance with eating. The weight record, provided by the ADON (Assistant Director of Nursing), indicated Resident #B's weights were as follows:		corrective action will be taken:No other residents were found to have been affected by the alleged deficient practiceResidents with weight loss requiring a low level table to facilitate dining have the potential to be affected by the alleged deficient practice.Skilled Occupational Therapists have screened residents in dining areas during meals to ensure table heights were appropratie for residents residing in the facility.The Dining Room Monitor ensures residents are seated at the appropriate table based on the Occupational Therapist's recommendation.The facility has ordered additional adjustable height tables to ensure residents requiring alternate height tables are accommodated.Skilled Occupational Therapists screen residents upon admission, monthly x 3, quarterly thereafter and as needed for appropriate positioning at meals.The facility Rehab Services Manager is responsible for oversight to ensure compliance.What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur:Skilled Occupational Therapists have screened residents in dining areas during meals to ensure table heights were appropratie for residents residing in the facility.The Dining Room Monitor ensures residents are seated at the appropriate	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155095	A. BUILDING 00 B. WING	10/21/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE PARK	2001 HOBSON RD FORT WAYNE, IN46805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 4/1/11, 99 pounds; On 5/1/11, 100 pounds; On 6/1/11, 96 pounds: On 7/1/11, 96 pounds; On 8/1/11, 95 pounds; On 9/1/11, 89 pounds; On 9/6/11, 88 pounds; and On 10/18/11 (the most current weight), was 84 pounds. The weight record indicated Resident #B lost 15 pounds or 15 percent of total body weight in six months (between 4/1/11 and 10/18/11) and lost 6 pounds or 6.3 per cent of total body weight in one month (between 8/1/11 and 9/1/11). An Occupational Therapy Screening, dated 9/14/11, indicated the resident was able to feed herself without difficulty and no recommendations were made. The interdisciplinary note, dated 9/28/11, indicated the resident's average consumption was 24% and indicated the resident was screened by the Speech Therapist. Speech therapy notes, dated 9/28/11, indicated the resident might benefit from a 4th meal group provided by therapy but the resident's power of attorney declined the therapy services. There were no further recommendations. On 10/21/11, the Speech Therapist		table based on the Occupational Therapist's recommendation.The facility has ordered additional adjustable height tables to ensure residents requiring alternate height tables are accommodated.Skilled Occupational Therapists screen residents upon admission, monthly x 3, quarterly thereafter and as needed for appropriate positioning at meals.The facility Rehab Services Manager is responsible for oversight to ensure compliance.How the corrective action(s) will be onitored to ensure the deficient practice will not recur:A CQI monitoring tool titled "Dining Positioning" will be utilized every week x 4, monthly x 3 and quarterly thereafter by the skilled therapist.Data will be submitted to the CQI committee. If threshold of 90% is not met; an action plan will be developed.Non-compliance with facility procedure may result in disciplinary action up to and including termination.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155095	A. BUILDING 00 B. WING	10/21/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE PARK	2001 HOBSON RD FORT WAYNE, IN46805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated she had observed the resident eating a snack in the therapy department but could not recall assessing her positioning at a meal. On 10/21/11 at 10:45 a.m., the DON (Director of Nursing) indicated she could not find a policy regarding the height of dining room tables. This Federal tag relates to Complaint IN00098450 3.1-19(w)(5)			